

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046060</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Eastview Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>Eastview Place</u> <u>Sullivan</u> <u>61951</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Moultrie</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(217) 728-7367</u> Fax # <u>(217) 728-8405</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518																									
IDPA ID Number: <u>371346306003</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>02/01/00</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace# 0046060 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>23,058</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>63</u>	TOTALS	<u>63</u>	<u>23,058</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,882</u>	<u>2,489</u>	<u>1,471</u>	<u>21,842</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,882</u>	<u>2,489</u>	<u>1,471</u>	<u>21,842</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.73%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Yes - Meals for Inmates

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 02/01/2000NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 8 and days of care provided 1,471Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	145,385	15,353		160,738		160,738	4,779	165,517		1
2	Food Purchase		120,368		120,368		120,368	(45,171)	75,197		2
3	Housekeeping	53,257	18,092		71,349		71,349	20	71,369		3
4	Laundry	32,081	16,720		48,801		48,801	(27)	48,774		4
5	Heat and Other Utilities			56,343	56,343		56,343	432	56,775		5
6	Maintenance	22,433	25,049	13,661	61,143		61,143	2,971	64,114		6
7	Other (specify):* Mgmt. Co. Benefits							851	851		7
8	TOTAL General Services	253,156	195,582	70,004	518,742		518,742	(36,145)	482,597		8
	B. Health Care and Programs										
9	Medical Director			13,350	13,350		13,350		13,350		9
10	Nursing and Medical Records	616,479	44,806	3,871	665,156		665,156	10,449	675,605		10
10a	Therapy			174,818	174,818		174,818	4	174,822		10a
11	Activities	16,787	395	4,551	21,733		21,733	5	21,738		11
12	Social Services	19,188	84		19,272		19,272		19,272		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt. Co. Benefits							1,010	1,010		15
16	TOTAL Health Care and Programs	652,454	45,285	196,590	894,329		894,329	11,468	905,797		16
	C. General Administration										
17	Administrative	32,061		184,821	216,882		216,882	(126,460)	90,422		17
18	Directors Fees										18
19	Professional Services			14,966	14,966		14,966	10,542	25,508		19
20	Dues, Fees, Subscriptions & Promotions			2,124	2,124		2,124	169	2,293		20
21	Clerical & General Office Expenses	14,281	3,961	10,263	28,505		28,505	36,061	64,566		21
22	Employee Benefits & Payroll Taxes			155,542	155,542		155,542		155,542		22
23	Inservice Training & Education			2,038	2,038		2,038	601	2,639		23
24	Travel and Seminar			677	677		677	1,277	1,954		24
25	Other Admin. Staff Transportation			3,752	3,752		3,752	2,453	6,205		25
26	Insurance-Prop.Liab.Malpractice			40,364	40,364		40,364	858	41,222		26
27	Other (specify):* Mgmt. Co. Benefits							9,899	9,899		27
28	TOTAL General Administration	46,342	3,961	414,547	464,850		464,850	(64,600)	400,250		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	951,952	244,828	681,141	1,877,921		1,877,921	(89,277)	1,788,644		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Eastview Terrace

#0046060

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			67,260	67,260		67,260	20,892	88,152			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,287	105,287		105,287	4,850	110,137			32
33	Real Estate Taxes			12,822	12,822		12,822	316	13,138			33
34	Rent-Facility & Grounds							2,462	2,462			34
35	Rent-Equipment & Vehicles			1,368	1,368		1,368	90	1,458			35
36	Other (specify):*											36
37	TOTAL Ownership			186,737	186,737		186,737	28,610	215,347			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,502		30,502		30,502		30,502			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,588	34,588		34,588		34,588			42
43	Other (specify):* Nonallowable Costs			18,207	18,207		18,207	(18,207)				43
44	TOTAL Special Cost Centers		30,502	52,795	83,297		83,297	(18,207)	65,090			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	951,952	275,330	920,673	2,147,955		2,147,955	(78,874)	2,069,081			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(44,873)	2	4
5	Telephone, TV & Radio in Resident Rooms	(2,227)	43	5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	16,641	30	9
10	Interest and Other Investment Income	(8)	32	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(1,060)	43	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions	(270)	43	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising	(3,624)	43	28
29	Other-Attach Schedule	(11,626)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,047)	\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(31,827)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,827)	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (78,874)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.	x	\$		38
39					39
40	Gift and Coffee Shops	x			40
41	Barber and Beauty Shops	x			41
42	Laboratory and Radiology	x			42
43	Prescription Drugs	x			43
44	Exceptional Care Program	x			44
45	Other-Attach Schedule	x			45
46	Other-Attach Schedule	x			46
47	TOTAL (C): (sum of lines 38-46)		\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace

ID# 0046060

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Labs - Part A	\$ (2,212)	43	1
2	X-Rays - Part A	(8,814)	43	2
3	Disallow Non-Allowable Dues & Subscriptions	(300)	20	3
4	Disallow Non-Allowable Vending Machine Expense	(300)	2	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,626)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
Provider #: 0046060
01/01/04 to 12/31/04

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	4,756	0	0	0	0	0	0	0	0	0	4,756	1
2	Food Purchase	(45,173)	2	0	0	0	0	0	0	0	0	0	(45,171)	2
3	Housekeeping	0	20	0	0	0	0	0	0	0	0	0	20	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	432	0	0	0	0	0	0	0	0	0	432	5
6	Maintenance	0	2,971	0	0	0	0	0	0	0	0	0	2,971	6
7	Other (specify):*	0	851	0	0	0	0	0	0	0	0	0	851	7
8	TOTAL General Services	(45,173)	9,032	0	0	0	0	0	0	0	0	0	(36,141)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10,449	0	0	0	0	0	0	0	0	0	10,449	10
10a	Therapy	0	4	0	0	0	0	0	0	0	0	0	4	10a
11	Activities	0	5	0	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,010	0	0	0	0	0	0	0	0	0	1,010	15
16	TOTAL Health Care and Programs	0	11,468	0	0	0	0	0	0	0	0	0	11,468	16
	C. General Administration													
17	Administrative	0	(126,460)	0	0	0	0	0	0	0	0	0	(126,460)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,542	0	0	0	0	0	0	0	0	0	10,542	19
20	Fees, Subscriptions & Promotions	(300)	469	0	0	0	0	0	0	0	0	0	169	20
21	Clerical & General Office Expenses	0	0	36,061	0	0	0	0	0	0	0	0	36,061	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	601	0	0	0	0	0	0	0	0	601	23
24	Travel and Seminar	0	0	1,277	0	0	0	0	0	0	0	0	1,277	24
25	Other Admin. Staff Transportation	0	0	2,453	0	0	0	0	0	0	0	0	2,453	25
26	Insurance-Prop.Liab.Malpractice	0	0	858	0	0	0	0	0	0	0	0	858	26
27	Other (specify):*	0	0	9,899	0	0	0	0	0	0	0	0	9,899	27
28	TOTAL General Administration	(300)	(115,449)	51,149	0	0	0	0	0	0	0	0	(64,600)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,473)	(94,949)	51,149	0	0	0	0	0	0	0	0	(89,273)	29

Summary B

12/31/04

[illegible]

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,756	\$ 4,756 1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	2	2 2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	20	20 3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	432	432 4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,971	2,971 5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	851	851 6
7	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,449	10,449 7
8	V	10A Therapy		Petersen Health Care, Inc.	100.00%	4	4 8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	5	5 9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,010	1,010 10
11	V	17 Administrative	184,821	Petersen Health Care, Inc.	100.00%	58,361	(126,460) 11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	10,542	10,542 12
13	V	20 Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	469	469 13
14	Total		\$ 184,821			\$ 89,872	\$ * (94,949) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 36,061	\$ 36,061
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	601	601
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,277	1,277
18	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,453	2,453
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	858	858
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,899	9,899
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,251	4,251
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,858	4,858
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	316	316
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	2,462	2,462
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	86	86
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 63,122	\$ * 63,122

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
Provider # 0046060
01/01/04 to 12/31/04

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,034,628	3	6.00	Salary	\$ 58,361	L17,C8	1
2											2
3											3
4											4
5											5
6		See attached Schedule 7A									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 58,361		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
provider # 0046060
01/01/04 to 12/31/04

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care Companies
 Street Address 7218 North Villa Lake
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	\$ 89,079	\$ 89,071	21,842	\$ 4,756	1
2	2	Food	Patient Days	409,056	18	33		21,842	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		21,842	20	3
4	5	Utilities	Patient Days	409,056	18	8,082		21,842	432	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	21,842	2,971	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		21,842	851	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	21,842	10,449	7
8	10A	Therapy	Patient Days	409,056	18	75		21,842	4	8
9	11	Activities	Patient Days	409,056	18	86		21,842	5	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		21,842	1,010	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	21,842	58,361	11
12	19	Professional Services	Patient Days	409,056	18	197,418		21,842	10,542	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		21,842	469	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	21,842	36,061	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		21,842	601	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		21,842	1,277	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		21,842	2,453	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		21,842	858	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		21,842	9,899	19
20	30	Depreciation	Patient Days	409,056	18	79,620		21,842	4,251	20
21	32	Interest	Patient Days	409,056	18	90,987		21,842	4,858	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		21,842	316	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		21,842	2,462	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		21,842	86	24
25	TOTALS					\$ 2,865,264	\$ 1,919,411		\$ 152,994	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of Farmington		X	Car purchase	\$499.00	03/28/01	\$ 11,987	\$	04/27/03	0.0790	\$ 2,120	1
2	LaSalle Bank		X	Mortgage	\$2044+int.	08/31/02	1,887,097	1,827,628	08/31/07	varies	98,092	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Working capital	Interest only	08/31/03	150,000		08/31/05	varies	5,075	6
7												7
8												8
9	TOTAL Facility Related				\$499.00		\$ 2,049,084	\$ 1,827,628			\$ 105,287	9
	B. Non-Facility Related*											
10												10
11							Allocated from Mgmt. Co.				4,858	11
12							Offset Interest Income				(8)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 4,850	14
15	TOTALS (line 9+line14)						\$ 2,049,084	\$ 1,827,628			\$ 110,137	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Eastview Terrace**# **0046060** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	10,506	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2003	\$	11,774	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,268	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	11,554	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Allocation from Home Office		316	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	13,138	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	10,402	8
	2000	10,589	9
	2001	10,417	10
	2002	10,598	11
	2003	11,774	12

2003 tax:	10,598		
Increase (9%)	1.09		
2004 tax:	11554		

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastview Terrace COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046060

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-08-01-202-037</u>	<u>Facility & Grounds</u>	\$ <u>11,774.00</u>	\$ <u>11,774.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>11,774.00</u>	\$ <u>11,774.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,082
 B. General Construction Type:
 Exterior Block
 Frame Steel
 Number of Stories One

C. Does the Operating Entity?
 [X] (a) Own the Facility
 [] (b) Rent from a Related Organization.
 [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 [X] (a) Own the Equipment
 [] (b) Rent equipment from a Related Organization.
 [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 [] YES
 [X] NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	217,546	2000	\$ 100,000	1
2					2
3	TOTALS	217,546		\$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	57	2000	1976	\$ 982,565	\$ 25,194	39	\$ 25,194	\$	\$ 125,970
5	6	2000	1985						
6									
7									
8									
Improvement Type**									
9	Water Heater	2000		4,800	428	7	686	258	3,086
10	Concrete Pad	2000		500	13	20	25	12	113
11	Painting Exterior Building	2000		2,480	286	5	496	210	2,232
12	Fence	2000		3,953	274	15	264	(10)	1,187
13	Asphalt Parking Lot	2000		2,370	164	15	158	(6)	711
14	Carpet	2000		503	45	7	72	27	324
15	Flooring	2001		72,265	1,853	39	1,853		6,485
16	Remodeling	2001		6,245	160	39	160		560
17	Roofing	2001		2,159	55	39	55		194
18	Roofing	2001		12,000	308	39	308		1,077
19	Replacement - Glass	2001		1,179	103	7	168	65	589
20	Medicare wing upgrade	2002		89,018	2,283	39	2,283		5,761
21	Roofing	2002		14,200	364	39	364		925
22	Flooring	2002		4,263	109	39	109		269
23	Architects Fee	2002		1,916	49	39	49		104
24	Wall hangings	2002		3,220	394	7	460	66	1,150
25	Paving of Parking Lot	2004		4,200	140	15	140		140
26	Window Balance	2004		1,714	245	7	122	(123)	122
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,209,549	\$ 32,467		\$ 32,966	\$ 499	\$ 150,998	70

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 273,198	\$ 27,771	\$ 39,786	\$ 12,015	5-7 years	\$ 174,651	71
72	Current Year Purchases	5,730	875	477	(398)	5-7 years	477	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company		4,251	4,251				74
75	TOTALS	\$ 278,926	\$ 32,897	\$ 44,514	\$ 11,617		\$ 175,128	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Plymouth Voyager 2000	2000	\$ 42,307	\$ 4,874	\$ 8,461	\$ 3,587	5	\$ 42,305	76
77	Resident Care	Malibu 2000	2001	11,054	1,273	2,211	938	5	7,738	77
78										78
79										79
80	TOTALS			\$ 53,361	\$ 6,147	\$ 10,672	\$ 4,525		\$ 50,044	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,641,836	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,511	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,152	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,641	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 376,170	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Allocated from Home Office			2,462			5
6								6
7	TOTAL				\$ 2,462			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

None
N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,458

Description: Oxygen Tanks - \$122; Copier - \$1,250; Allocated from Home Office - \$86
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$
13. /2006 \$
14. /2007 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A, C3	hrs	\$	1,176	\$ 70,553	\$	1,176	\$ 70,553	1
2	Licensed Speech and Language Development Therapist	10A, C3	hrs		444	26,653		444	26,653	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A, C3	hrs		1,294	77,612		1,294	77,612	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				23,579		23,579	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39(2)					6,923		6,923	13
14	TOTAL			\$	2,914	\$ 174,818	\$ 30,502	2,914	\$ 205,320	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
Provider #: 0046060
01/01/04 to 12/31/04

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	---------------------------	-------------------------------------	-------------	-----------------

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 760,281	\$ 760,281	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	430,138	430,138	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	687,672	687,672	8
9	Other(specify): <u>Employee Advances</u>	8,839	8,839	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,886,930	\$ 1,886,930	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	1,209,549	1,209,549	14
15	Leasehold Improvements, at Historical Cost	(140)		15
16	Equipment, at Historical Cost	332,287	332,287	16
17	Accumulated Depreciation (book methods)	(408,577)	(376,170)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill, net of amortization</u>	320,669	320,669	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,553,788	\$ 1,586,335	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,440,718	\$ 3,473,265	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 247,478	\$ 247,478	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,755	41,755	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,648	11,554	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached Schedule 17A</u>	30,609	30,609	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 331,490	\$ 331,396	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,827,628	1,827,628	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,827,628	\$ 1,827,628	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,159,118	\$ 2,159,024	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,281,600	\$ 1,314,241	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,440,718	\$ 3,473,265	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Eastview Terrace
Provider # 0046060
01/01/04 to 12/31/04

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities

Line 36, Other Current Liabilities (specify):

	Operating	After Consolidation
Accrued Vacation	23,073	23,073
Wage Garnishment	787	787
Accrued Sales Tax	254	254
Accrued Insurance	71	71
Accrued Expenses - Other	6,424	6,424
Total	30,609	30,609

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 902,855	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	(65,108)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 837,747	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	443,853	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 443,853	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,281,600	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,129,842	1
2	Discounts and Allowances for all Levels	54,430	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,184,272	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	309,625	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 309,625	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	44,873	14
15	Telephone, Television and Radio	616	15
16	Rental of Facility Space		16
17	Sale of Drugs	46,095	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,123	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,970	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 95,677	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,926	28
28a	Vending Income	300	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,226	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,591,808	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	518,742	31
32	Health Care	894,329	32
33	General Administration	464,850	33
B. Capital Expense			
34	Ownership	186,737	34
C. Ancillary Expense			
35	Special Cost Centers	48,709	35
36	Provider Participation Fee	34,588	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,147,955	40
41	Income before Income Taxes (line 30 minus line 40)**	443,853	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 443,853	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,993	1,994	\$ 40,245	\$ 20.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,356	4,508	81,082	17.99	3
4	Licensed Practical Nurses	10,243	10,634	162,901	15.32	4
5	Nurse Aides & Orderlies	33,556	34,721	320,392	9.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,033	2,033	16,787	8.26	9
10	Activity Assistants					10
11	Social Service Workers	1,590	1,590	19,188	12.07	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,962	13.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,179	15,012	116,423	7.76	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,088	22,433	10.74	17
18	Housekeepers	7,359	7,545	53,257	7.06	18
19	Laundry	4,348	4,521	32,081	7.10	19
20	Administrator	1,436	1,468	32,061	21.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,297	1,297	14,281	11.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Coordinator	961	961	11,859	12.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,511	90,452	\$ 951,952 *	\$ 10.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	13,350	Ln 9, C 3	36
37	Medical Records Consultant	monthly	625	Ln 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	400	Ln 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Rehabilitation Consultant	monthly	2,846	Ln 10, C 3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,221		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS

0046060

Page 21

Report Period Beginning: 01/01/04 Ending: 12/31/04

<p>A. Administrative Salaries</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Name</th> <th style="width: 15%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 45%;">Amount</th> </tr> <tr> <td><u>Angela Edwards</u></td> <td><u>Administrator</u></td> <td><u>0</u></td> <td style="text-align: right;">\$ <u>32,061</u></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ <u>32,061</u></td> </tr> </table> <p>B. Administrative - Other</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 70%;">Description</th> <th style="width: 30%;">Amount</th> </tr> <tr> <td><u>Management fees (eliminated in column 7)</u></td> <td style="text-align: right;">\$ <u>184,821</u></td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td style="text-align: right;">\$ <u>184,821</u></td> </tr> </table> <p>C. Professional Services</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Vendor/Payee</th> <th style="width: 20%;">Type</th> <th style="width: 50%;">Amount</th> </tr> <tr> <td><u>Altschuler, Melvoin & Glasser</u></td> <td><u>Accounting</u></td> <td style="text-align: right;">\$ <u>6,675</u></td> </tr> <tr> <td><u>Bush, Snyder & Assoc.</u></td> <td><u>Legal</u></td> <td style="text-align: right;">649</td> </tr> <tr> <td><u>ADP</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">5,325</td> </tr> <tr> <td><u>IVANS</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">613</td> </tr> <tr> <td><u>AdminaStar Federal</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">119</td> </tr> <tr> <td><u>McKesson Medical</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">37</td> </tr> <tr> <td><u>One Eleven Internet Service</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">110</td> </tr> <tr> <td><u>Arch Wireless</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">118</td> </tr> <tr> <td><u>LTC Solutions</u></td> <td><u>Computer Services</u></td> <td style="text-align: right;">1,320</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)</td> <td> </td> <td style="text-align: right;">\$ <u>14,966</u></td> </tr> </table>	Name	Function	Ownership %	Amount	<u>Angela Edwards</u>	<u>Administrator</u>	<u>0</u>	\$ <u>32,061</u>																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>32,061</u>	Description	Amount	<u>Management fees (eliminated in column 7)</u>	\$ <u>184,821</u>					TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ <u>184,821</u>	Vendor/Payee	Type	Amount	<u>Altschuler, Melvoin & Glasser</u>	<u>Accounting</u>	\$ <u>6,675</u>	<u>Bush, Snyder & Assoc.</u>	<u>Legal</u>	649	<u>ADP</u>	<u>Computer Services</u>	5,325	<u>IVANS</u>	<u>Computer Services</u>	613	<u>AdminaStar Federal</u>	<u>Computer Services</u>	119	<u>McKesson Medical</u>	<u>Computer Services</u>	37	<u>One Eleven Internet Service</u>	<u>Computer Services</u>	110	<u>Arch Wireless</u>	<u>Computer Services</u>	118	<u>LTC Solutions</u>	<u>Computer Services</u>	1,320							TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ <u>14,966</u>	<p>D. Employee Benefits and Payroll Taxes</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> <tr> <td><u>Workers' Compensation Insurance</u></td> <td style="text-align: right;">\$ <u>35,988</u></td> </tr> <tr> <td><u>Unemployment Compensation Insurance</u></td> <td style="text-align: right;">14,002</td> </tr> <tr> <td><u>FICA Taxes</u></td> <td style="text-align: right;">71,054</td> </tr> <tr> <td><u>Employee Health Insurance</u></td> <td style="text-align: right;">29,455</td> </tr> <tr> <td><u>Employee Meals</u></td> <td> </td> </tr> <tr> <td><u>Illinois Municipal Retirement Fund (IMRF)*</u></td> <td> </td> </tr> <tr> <td><u>Employee Life Insurance</u></td> <td style="text-align: right;">602</td> </tr> <tr> <td><u>401(k) Management Fees</u></td> <td style="text-align: right;">2,068</td> </tr> <tr> <td><u>Employee Relations</u></td> <td style="text-align: right;">2,373</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td style="text-align: right;">\$ <u>155,542</u></td> </tr> </table> <p>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 40%;">Description</th> <th style="width: 10%;">Line #</th> <th style="width: 50%;">Amount</th> </tr> <tr> <td><u>N/A</u></td> <td> </td> <td> </td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td>TOTAL</td> <td> </td> <td style="text-align: right;">\$ <u> </u></td> </tr> </table>	Description	Amount	<u>Workers' Compensation Insurance</u>	\$ <u>35,988</u>	<u>Unemployment Compensation Insurance</u>	14,002	<u>FICA Taxes</u>	71,054	<u>Employee Health Insurance</u>	29,455	<u>Employee Meals</u>		<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Employee Life Insurance</u>	602	<u>401(k) Management Fees</u>	2,068	<u>Employee Relations</u>	2,373							TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>155,542</u>	Description	Line #	Amount	<u>N/A</u>																											TOTAL		\$ <u> </u>	<p>F. 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Name	Function	Ownership %	Amount																																																																																																																																																																																																			
<u>Angela Edwards</u>	<u>Administrator</u>	<u>0</u>	\$ <u>32,061</u>																																																																																																																																																																																																			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>32,061</u>																																																																																																																																																																																																			
Description	Amount																																																																																																																																																																																																					
<u>Management fees (eliminated in column 7)</u>	\$ <u>184,821</u>																																																																																																																																																																																																					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ <u>184,821</u>																																																																																																																																																																																																					
Vendor/Payee	Type	Amount																																																																																																																																																																																																				
<u>Altschuler, Melvoin & Glasser</u>	<u>Accounting</u>	\$ <u>6,675</u>																																																																																																																																																																																																				
<u>Bush, Snyder & Assoc.</u>	<u>Legal</u>	649																																																																																																																																																																																																				
<u>ADP</u>	<u>Computer Services</u>	5,325																																																																																																																																																																																																				
<u>IVANS</u>	<u>Computer Services</u>	613																																																																																																																																																																																																				
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<u>McKesson Medical</u>	<u>Computer Services</u>	37																																																																																																																																																																																																				
<u>One Eleven Internet Service</u>	<u>Computer Services</u>	110																																																																																																																																																																																																				
<u>Arch Wireless</u>	<u>Computer Services</u>	118																																																																																																																																																																																																				
<u>LTC Solutions</u>	<u>Computer Services</u>	1,320																																																																																																																																																																																																				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ <u>14,966</u>																																																																																																																																																																																																				
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* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Eastview Terrace
Provider #: 0046060
01/01/04 to 12/31/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 14,966

Allocated from Home Office - Legal 1,724

Allocated from Home Office - Other 8,818

Total (agree to Schedule V, line 19, column 8) 25,508

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Eastview Terrace**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,878 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,588
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 44,873
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet complete.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	145,385	15,353	0	160,738	0	160,738	4,779	165,517
2. Food Purchase	0	120,368	0	120,368	0	120,368	-45,171	75,197
3. Housekeeping	53,257	18,092	0	71,349	0	71,349	20	71,369
4. Laundry	32,081	16,720	0	48,801	0	48,801	-27	48,774
5. Heat and Other Utilities	0	0	56,343	56,343	0	56,343	432	56,775
6. Maintenance	22,433	25,049	13,661	61,143	0	61,143	2,971	64,114
7. Other (specify)*	0	0	0	0	0	0	851	851
8. Total General Services	253,156	195,582	70,004	518,742	0	518,742	-36,145	482,597
9. Medical Director	0	0	13,350	13,350	0	13,350	0	13,350
10. Nursing & Medical Records	616,479	44,806	3,871	665,156	0	665,156	10,449	675,605
10a. Therapy	0	0	174,818	174,818	0	174,818	4	174,822
11. Activities	16,787	395	4,551	21,733	0	21,733	5	21,738
12. Social Services	19,188	84	0	19,272	0	19,272	0	19,272
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	1,010	1,010
16. Total Health Care & Programs	652,454	45,285	196,590	894,329	0	894,329	11,468	905,797
17. Administrative	32,061	0	184,821	216,882	0	216,882	-126,460	90,422
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	14,966	14,966	0	14,966	10,542	25,508
20. Fees, Subscriptions & Promotion	0	0	2,124	2,124	0	2,124	169	2,293
21. Clerical & General Office	14,281	3,961	10,263	28,505	0	28,505	36,061	64,566
22. Employee Benefits & Payroll	0	0	155,542	155,542	0	155,542	0	155,542
23. Inservice Training & Education	0	0	2,038	2,038	0	2,038	601	2,639
24. Travel and Seminar	0	0	677	677	0	677	1,277	1,954
25. Other Admin. Staff Trans	0	0	3,752	3,752	0	3,752	2,453	6,205
26. Insurance-Prop.Liab.Malpractice	0	0	40,364	40,364	0	40,364	858	41,222
27. Other (specify)*	0	0	0	0	0	0	9,899	9,899
28. Total General Adminis	46,342	3,961	414,547	464,850	0	464,850	-64,600	400,250
29. Total General Administrative	951,952	244,828	681,141	1,877,921	0	1,877,921	-89,277	1,788,644
30. Depreciation	0	0	67,260	67,260	0	67,260	20,892	88,152
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	105,287	105,287	0	105,287	4,850	110,137
33. Real Estate	0	0	12,822	12,822	0	12,822	316	13,138
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,462	2,462
35. Rent - Equipment & Vehicles	0	0	1,368	1,368	0	1,368	90	1,458
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	186,737	186,737	0	186,737	28,610	215,347
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	30,502	0	30,502	0	30,502	0	30,502
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	34,588	34,588	0	34,588	0	34,588
43. Other (specify):*	0	0	18,207	18,207	0	18,207	-18,207	0
44. Total Special Cost Ce	0	30,502	52,795	83,297	0	83,297	-18,207	65,090
45. Grand Total	951,952	275,330	920,673	2,147,955	0	2,147,955	-78,874	2,069,081

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	760,281	760,281
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	430,138	430,138
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	687,672	687,672
9. Other (specify):	8,839	8,839
10. Total current assets	1,886,930	1,886,930
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	100,000	100,000
14. Buildings, at Historical Cost	1,209,549	1,209,549
15. Leasehold Improvements, Historical Cost	-140	0
16. Equipment, at Historical Cost	332,287	332,287
17. Accumulated Depreciation (book methods)	-408,577	-376,170
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	320,669	320,669
24. Total Long-Term Assets	1,553,788	1,586,335
25. Total Assets	3,440,718	3,473,265
CURRENT LIABILITIES		
26. Accounts Payable	247,478	247,478
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	41,755	41,755
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	11,648	11,554
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	30,609	30,609
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	331,490	331,396
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	1,827,628	1,827,628
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	1,827,628	1,827,628
46. Total Liabilities	2,159,118	2,159,024
47. Total Equity	1,281,600	1,314,241
48. Total Liabilities and Equity	3,440,718	3,473,265

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,129,842
2. Discounts and Allowances for all Levels	54,430
Subtotal - Inpatient Care	2,184,272
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	309,625
7. Oxygen	0
Subtotal - Ancillary Revenue	309,625
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	44,873
15. Telephone, Television, and Radio	616
16. Rental of Facility Space	0
17. Sale of Drugs	46,095
18. Sale of Supplies to Non-Patients	0
19. Laboratory	2,123
20. Radiology and X-Ray	0
21. Other Medical Services	1,970
22. Laundry	0
Subtotal - Other Operating Revenue	95,677
24. Contributions	0
25. Interest and Other Investments Income	8
Subtotal - Non-Operating Revenue	8
27. Other Revenue (specify):	300
28. Other Revenue (specify):	1,926
Subtotal - Other Revenue	2,226
30. Total Revenue	2,591,808
31. General Services	518,742
32. Health Care	894,329
33. General Administration	464,850
34. Ownership	186,737
35. Special Cost Centers	48,709
35. Provider Participation Fee	34,588
37. Other	0
40. Total Expenses	2,147,955
41. Income Before Income Taxes	443,853
42. Income Taxes	0
43. Net Income or Loss for the Year	443,853

Page

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